MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03764 03760

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 26 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7 Creamery Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Easton
d. STREET ADDRESS: 7 Creamery Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Jefferson — Last: Alderman

4. DATE OF DEATH: Month: March — Day: 7 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1888

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: State Roads

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Alderman

14. MOTHER'S MAIDEN NAME: Mary Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Levinia Alderman, Address: 7 Creamery Lane, Easton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 HR
DUE TO
(b): Arteriosclerotic Heart Disease — YRS.
DUE TO
(c):

Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse lost.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to 3/7 1962 that (I) (we) last saw the deceased alive on 3/7 1962 and that death occurred at 2P.M. from the causes and on the date stated above.

22a. SIGNATURE: Shepard Krech Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/8/62

22c. PHYSICIAN'S NAME (Type): Shepard Krech, Jr., M.D.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/10/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town, or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll
ADDRESS: Easton, Md.
W. Frampton Carroll

25a. REC'D BY REGISTRAR DATE: MAR 13 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03765

CERTIFICATE OF DEATH

03761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYland — b. COUNTY: talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. 1 - Box 127
   d. STREET ADDRESS: CORDOVA
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JAMES — Middle: EDWARD — Last: BOWSER

4. **DATE OF DEATH**: Month: 3 — Day: 5 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 23, 1912

9. AGE (In years last birthday): 99 yrs.
   IF UNDER 1 YEAR: Months | Days
   IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Lumber-Mill

11. BIRTHPLACE (County & State, or foreign country): MARYland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES E. BOWSER

14. MOTHER'S MAIDEN NAME: MARY HARRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
   (If yes give were or dates of service):

16. SOCIAL SECURITY NO.: 215-20-1204

17. INFORMANT: EMMA BOWSER — Address: CORDOVA, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: < 24 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-4, 1962 to 3-5, 1962 that (I) (we) last saw the deceased alive on 3-4 1962, and that death occured at 7:53 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert W. Trever

22d. ADDRESS: EASTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3-8-62

23c. NAME OF CEMETERY OR CREMATORY: Newtown Cem.

23d. LOCATION (City, town or county) (State): Skipton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James L. Caskill

ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03766 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03762

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely 05x-2
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joyce Middle Ann Last Buckle
4. DATE OF DEATH: Month March Day 30 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 24, 1961
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 3 Days 8; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Theadore E. Buckle
14. MOTHER'S MAIDEN NAME: Ethel M. Knight
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Theadore Buckle Ridgely, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspirational Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
7620
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Dawson D George M.D.
EXAMINER'S NAME (Type): DAWSON D George
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-31-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-2-62
22c. NAME OF CEMETERY OR CREMATORY: Greensboro
22d. LOCATION (City, or country) (State): Greensboro, Maryland

23. FUNERAL DIRECTOR ADDRESS: J. E. Boulais, Greensboro Md.
24a. REC'D BY REGISTRAR DATE: APR 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

1-009765

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, ... execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and ... to the funeral director. Page ... should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 m... retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 wi... the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03767 (top) 03763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Easton
   d. STREET ADDRESS: 1 Goldsboro
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: ~~Frances~~ Fannie — Middle: A. — Last: Callahan

4. **DATE OF DEATH**: Month: March — Day: 14 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: April 8 1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months: 11 Days: 7 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Andrew Maher

14. MOTHER'S MAIDEN NAME: Maria Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss: Ann G Callahan — Address: Goldsboro St Easton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Advanced Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

~~DUE TO~~ (b): Broncho-pneumonia, right

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on March 14 19 62, and that death occured at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 15 March 1962

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Mckp

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Easton Md

24 FUNERAL DIRECTOR'S SIGNATURE: Allen Buck

ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03768

CERTIFICATE OF DEATH

03764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 3days 18hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital Inc.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg 05x-2
d. STREET ADDRESS: Academy & University Avenues
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Marie (MARIE) Middle Woodington (W) Last Cantner (CANTNER)

4. **DATE OF DEATH**: Month March — Day 6 — Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 11, 1895
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William C. Woodington
14. MOTHER'S MAIDEN NAME: Clara Yerkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Mrs. Frank M. Anderson, Federalsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.0
DUE TO (b): Arteriosclerotic Heart disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-2, 1962 to 3-6, 1962, that (I) (we) last saw the deceased alive on MARCH 6 1962 and that death occured at 5:08 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D.
ATTENDING PHYS. X ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/62
22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D.
22d. ADDRESS: Easton, Maryland 3/6/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 8, 1962
23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery
23d. LOCATION (City, town or county) (State): Federalsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. J. Frampton Son, Federalsburg, Md.
25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03769

CERTIFICATE OF DEATH

03765

1. **PLACE OF DEATH**
a. COUNTY TALBOT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 19 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Easton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print) First Florence — Middle Taylor — Last Dryden

4. **DATE OF DEATH** Month March — Day 16 — Year 1962

5. SEX Female — 6. COLOR OR RACE White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH June 14, 1883 — 9. AGE (In years last birthday) 78 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (County & State, or foreign country) New Jersey — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Allen Taylor — 14. MOTHER'S MAIDEN NAME Carrie B. Whitehouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Nd — (If yes give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Address Mrs. Fannie D. Fonk — Belmont Hills, N.J.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH ?

4209 DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/12, 19—, to 3/16, 1962 that (I) (we) last saw the deceased alive on 3/16, 1962, and that death occured at 12:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED 3/16/62

22c. PHYSICIAN'S NAME (Type) P.E. Cox M.D. — 22d. ADDRESS Earle Ave. Easton, Maryland 3/16/62

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION — 23b. DATE THEREOF MAR. 19, 1962 — 23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory — 23d. LOCATION (City, town or county) Baltimore (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE Maurice F. Newnam & Son — ADDRESS Easton, Md. — 25a. REC'D BY REGISTRAR DATE MAR 19 '62 — 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03770 Reg. Dist. No. 03766

1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio VISTA NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY QUEEN ANNE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTER 17X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Daisy Middle: Last: Gardner

4. DATE OF DEATH Month: March Day: 2 Year: 1962

5. SEX: Fem.
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: APRIL 28-1872
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FELIX E BROWN
14. MOTHER'S MAIDEN NAME: CLARA MILBURN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Jack Gardner = Chester, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchio Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Influenza type cold — 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
480X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Vascular Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 Jan, 1952, to 2 March, 1962, that I last saw the deceased alive on 1 March, 1962, and that death occurred at 4:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Lane Wroth M.D. ADDRESS (Street, city or town, state): Box 487, St Michaels, Md DATE SIGNED: 3-2-62
PHYSICIAN'S NAME (Type): R. LANE WROTH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAR. 4
22c. NAME OF CEMETERY OR CREMATORY: STEVENSVILLE
22d. LOCATION (City, town, or county) (State): STEVENSVILLE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill, Md
24a. REC'D BY REGISTRAR DATE: MAR 8 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TALBOT

ST. MICHAELS

Rio Vista Nursing Home

Dais[illegible]

FEM. WHITE X

HOUSEWIFE

MARYLAND

CHESTER

Queen Anne

X

Married 2 62

Gardner

USA

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03771

CERTIFICATE OF DEATH

03767

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- McDaniel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: at home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- McDaniel
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Norman — Middle: Lewis — Last: Hearn

4. DATE OF DEATH: Month: March — Day: 1 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1896

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Hearn

14. MOTHER'S MAIDEN NAME: Sarah Emily Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: Ukn.

17. INFORMANT: Mrs. Virginia Clarke Hearn, McDaniel, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
DUE TO
(b): Myocardial Infarction — 4 wks.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 27 Jan, 1962, to 1 March, 1962 that (I) (~~we~~) last saw the deceased alive on 28 Feb 1962 and that death occurred at 9:25 M, from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth, M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/4/62

23c. NAME OF CEMETERY OR CREMATORY: Mount Olive Cemetery

23d. LOCATION (City, town, or county) (State): Delmar, Delaware

24. FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll

ADDRESS: St. Michaels, Md.

25a. REC'D BY REGISTRAR DATE: MAR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Powell

W. Frampton Carroll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03772

CERTIFICATE OF DEATH

03768

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural- Trappe
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): "Windy Hill"

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural- Trappe
d. STREET ADDRESS: "Windy Hill"
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: --- — Last: Helfrich

4. DATE OF DEATH: Month: March — Day: 3, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 20, 1880

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Holland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Helfrich

14. MOTHER'S MAIDEN NAME: --- Aardema

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 215 38 1311A

17. INFORMANT: Miss Ruth Helfrich, Address: Trappe, RD, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

INTERVAL BETWEEN ONSET AND DEATH: (a) 10 min. (b) years (c) ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour: o. m. / p. m.; 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 19 55 to March 3, 19 62, that (I) (~~we~~) last saw the deceased alive on 3-3- 1962, and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Donald F. Bartley M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3-5-62

22c. PHYSICIAN'S NAME (Type): Donald F. Bartley, M.D.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/7/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town, or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll

ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 7 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Hanna

W. Frampton Carroll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, as filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03773

CERTIFICATE OF DEATH

03769

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 11 hrs 42 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely
d. STREET ADDRESS: 05X.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clifton — Middle: Ernest — Last: Henry

4. DATE OF DEATH: Month: March — Day: 2 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-11-95

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Janitor

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Asbury Henry

14. MOTHER'S MAIDEN NAME: Grace Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-32-8250

17. INFORMANT Address: Mayie Henry, Ridgely, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, etiology unknown — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO (b): 493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1, 1962 to 3-2, 1962 that (I) (we) last saw the deceased alive on 3-1 1962, and that death occured at 3:37 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert W. Trever, M.D.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-6-62

23c. NAME OF CEMETERY OR CREMATORY: Spring Grove, Cem

23d. LOCATION (City, town or county) (State): Denton Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James E. Corliell, Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03774 **CERTIFICATE OF DEATH** 03770

Inf. from birth certificate

1. PLACE OF DEATH
a. COUNTY TALBOT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 33 1/2 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cordova
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Baby Middle: Girl Last: Jacobs. (B)

4. DATE OF DEATH Month: 3 Day: 7 Year: 1962

5. SEX: female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/6/62

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR Months: Days: 1

IF UNDER 24 HRS. Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): newborn

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Memorial Hospital

12. CITIZEN OF WHAT COUNTRY? Md.

13. FATHER'S NAME: Samuel Flamer

14. MOTHER'S MAIDEN NAME: Rita Jean Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: mother Address: Cordova, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
776X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 6, 1962 to March 7, 1962, that (I) (we) last saw the deceased alive on March 7, 1962, and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE Kurt Lederer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 4/4/62

22c. PHYSICIAN'S NAME (Type) KURT LEDERER

22d. ADDRESS QUEEN ANNE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): incineration

23b. DATE THEREOF 3/10/62

23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

23d. LOCATION (City, town or county) (State): Easton, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: incineration ADDRESS: Memorial Hospital, Easton, Md.

25a. REC'D BY REGISTRAR DATE APR 9 '62

25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

2-059533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

Item 18 Film 309 3-21-62

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03775 03771

1. PLACE OF DEATH
a. COUNTY: TALBOT
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 70 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 401 S. WASHINGTON ST

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 EASTON
d. STREET ADDRESS: 401 S. WASHINGTON ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle SUPPES Last LEWIS.

4. DATE OF DEATH: Month 3/9/62 Day Year 19

5. SEX: MALE

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT- 2 1906

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: MEAT PRODUCTS

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: TELFORD LEWIS

14. MOTHER'S MAIDEN NAME: MARY S. SUPPES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ~~[illegible]~~ 193-21-3506

17. INFORMANT: MRS. TELFORD LEWIS. Address: 401 WASHINGTON ST EASTON, MD

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1/Pending Suffocation due to CNS depression — INTERVAL BETWEEN ONSET AND DEATH

322.2

DUE TO (b): and suppression of cough reflex by alcohol --0.15mgm%-

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): in an adult with severe asthmatic bronchitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis D Welty M.D.

EXAMINER'S NAME (Type): INDEFTY

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 3-10-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 15th

22c. NAME OF CEMETERY OR CREMATORY: GRANDVIEW CEMETERY

22d. LOCATION (City, town, or country) (State): JOHNSTOWN, PA.

23. FUNERAL DIRECTOR: [signature]

ADDRESS: EASTON, MD

24a. REC'D BY REGISTRAR DATE: MAR 13 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 2 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03776

CERTIFICATE OF DEATH

03772

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: ENTIRE LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 EASTON
   d. STREET ADDRESS: 1 MATTHEWS TOWN RD.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Harvey — Middle: R — Last: Marshall

4. **DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 7, 1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GENERAL WORK.

10b. KIND OF BUSINESS OR INDUSTRY: RIBBON FACTORY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES - MARSHALL

14. MOTHER'S MAIDEN NAME: HENRIETTA BALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): No — (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-30-9275

17. **INFORMANT** Address: MRS. EDITH MARSHALL EASTON MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): atherosclerotic - obstructive coronary
DUE TO (c): artery d, chronic myocardial

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): anoxia + Chronic Hypertension, Emphysema.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1959 19.., to 3-1- 62, 19.., that (I) (we) last saw the deceased alive on 2-12 1962 and that death occured at ..M, from the causes and on the date stated above.

22a. SIGNATURE: John Reese Jr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-1-62

22c. PHYSICIAN'S NAME (Type): John M Reese Jr

22d. ADDRESS: St Michaels md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAR. 5, 1962

23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEM.

23d. LOCATION (City, town or county): EASTON (State): MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Maude E. Newnam — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR DATE: MAR 5 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03777 **CERTIFICATE OF DEATH** 03773

Item 2 Film 6310 4/2/62 mh

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 16 days.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: [illegible] Caroli
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro — 05X-2
   d. STREET ADDRESS:
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: HARRIett — Middle: AtKinson — Last: MASSey

4. **DATE OF DEATH**: Month: MARch — Day: 17 — Year: 1962

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: Sept. 15, 1867 — 9. AGE (In years last birthday): 94 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (County & State, or foreign country): Kent Co. Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William W. Atkinson — 14. MOTHER'S MAIDEN NAME: Matilda Castin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give wer or dates of service): no — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT: Records of Home for Aged Women — Address: Easton Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Cerebral thrombosis, basilar artery — INTERVAL BETWEEN ONSET AND DEATH: < 3 days
- DUE TO (b):
- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Cerebral arteriosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fractured femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3- 1962 to 3-16 1962 thet (I) (we) lest saw the deceased alive on 3-16 1962, and that death occured at 6.43 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert W. Trever, M.D. — 22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 19, 1962 — 23c. NAME OF CEMETERY OR CREMATORY: Greensboro Cem — 23d. LOCATION (City, town or county): Greensboro (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Tilman & Son — ADDRESS: Easton Md. — 25a. REC'D BY REGISTRAR DATE MAR 22 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03778

CERTIFICATE OF DEATH

03774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: Thours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital Inc

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: PA — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia 75x3
   d. STREET ADDRESS: 4150 Parkside Ave — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: HARRY — Middle: — — Last: Matz

4. **DATE OF DEATH**: Month: MARCH — Day: 4 — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: — 1884

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refinisher

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (County & State, or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Minnie Sommers — Address: Easton Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Yrs.
DUE TO (b): Generalized Arteriosclerosis — Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

42.0.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 3-3- 1962, to 3-4- 1962, that (I) (~~we~~) last saw the deceased alive on 3-4- 1962, and that death occured at 3:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Donald F. Bartley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-4-62

22c. PHYSICIAN'S NAME (Type): DONALD F. BARTLEY M.D.

22d. ADDRESS: EASTON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 6-1962

23c. NAME OF CEMETERY OR CREMATORY: Mt Lebanon Cemetery

23d. LOCATION (City, town or county): Collingdale (State) Pa.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: S. Hampton Harrison, St. Michaels Md.

25a. REC'D BY REGISTRAR DATE: MAR 7 '62

25b. REGISTRAR'S SIGNATURE: William S. Travis

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03779 (crossed out) 03775

1

M

90

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): St. Michaels MD
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rio-Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
0913.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: W. — Last: McGowan

4. DATE OF DEATH: Month: March — Day: 13 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov 24 1871

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Clarence McGowan, New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Influenza, Type unk — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Dis 10 yr
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Parkinsonism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 24 June, 1961, to 13 March, 1962, that (I) (~~we~~) last saw the deceased alive on 12 March 19 62 and that death occured at 9:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): R. Lane Wroth, M.D.

22d. ADDRESS: St. Michaels, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-23-62

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town or county) (State): Brooklyn, New York

24 FUNERAL DIRECTOR'S SIGNATURE: S. Hampton Harrison, Jr. — ADDRESS: St. Michaels, Md

25a. REC'D BY REGISTRAR DATE: MAR 16 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Kemp

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03780

CERTIFICATE OF DEATH

03776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: 8 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Easton Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Queen Anne ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville 17X-2
   d. STREET ADDRESS: Box 99 Rt 1,
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: James — Middle: Edward — Last: Miller

4. **DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Mar. 26 - 93

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm

10b. KIND OF BUSINESS OR INDUSTRY: Farm tenant

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Miller

14. MOTHER'S MAIDEN NAME: Lillie Dobson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
    (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: 215-36-1919

17. INFORMANT — Address: Virgie F. Miller, Centreville, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: >2 wks

DUE TO (b): Arteriosclerotic heart disease — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 42.00

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20e. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to 3-1 ....., 1962 that (I) (we) last saw the deceased alive on 3-1 1962 and that death occured at 9:10 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Robert W. Trever

22d. ADDRESS: Easton md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 3-5-62 — 23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cem. — 23d. LOCATION (City, town or county) (State): Centreville Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James L. Dashiell — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR — DATE: MAR 6 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03781

CERTIFICATE OF DEATH

Item 4 Film G308 3/12/62 iwk

03777

1. PLACE OF DEATH
a. COUNTY: Talbot
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: Entire Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 517 August St. 29 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Mary Elizabeth Middle: Pritchard Last:

4. DATE OF DEATH: Month: March Day: 6, Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 12, 1875

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: same

11. BIRTHPLACE (County & State, or foreign country): Talbot Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard H. Pritchard

14. MOTHER'S MAIDEN NAME: Louisa Craft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Myrl Smith Address: Easton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b): Generalized Arterio sclerosis — 4 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June 19 25 to 3-6- 19 62, that (I) (~~we~~) last saw the deceased alive on 3-6- 19 62, and that death occured at 12 45 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Donald F. Bartley M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-7-62
22c. PHYSICIAN'S NAME (Type): DONALD F. BARTLEY M.D.
22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 8, 1962
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cem.
23d. LOCATION (City, town or county) (State): Easton Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Maurice E Newnam & Son
ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03782

CERTIFICATE OF DEATH

03778

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON 05X·2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: C — Last: Roe

4. DATE OF DEATH: Month: March — Day: 3 — Year: 1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W		JAN 9, 1881	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Maryland	USA

13. FATHER'S NAME: Andrew Jackson
14. MOTHER'S MAIDEN NAME: Lucinda Calloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Alma Jane Pepper — Address: Denton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	Unknown
DUE TO (c)		

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-28 1962 to 3-3, 1962 that (I) (we) last saw the deceased alive on 3-3 1962., and that death occured at 9:40 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/6/62

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M.D. — 22d. ADDRESS: Easton, Maryland — 3/6/62

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	MAR 6, 1962	DENTON	Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Virgil Moore — ADDRESS: Denton

25e. REC'D BY REGISTRAR DATE: MAR 9 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03783

CERTIFICATE OF DEATH

03779

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 13 hrs. 55 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON
d. STREET ADDRESS: 05 X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Spencer — Last: Ross

4. DATE OF DEATH: Month: 3 — Day: 23 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JUNE 10, 1891

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BAKERY OWNER

10b. KIND OF BUSINESS OR INDUSTRY: BAKERY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: SPENCER ROSS

14. MOTHER'S MAIDEN NAME: JOSEPHINE THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Wm. Spencer Ross, Denton

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs.
DUE TO (b): Chronic essential hypertension — (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 22 Mar, 1962 to 23 Mar, 1962, that (I) (we) last saw the deceased alive on 23 Mar 1962, and that death occured at 12:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thurston Harrison M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 23 Mar 62

22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: MAR. 26, 1962

23c. NAME OF CEMETERY OR CREMATORY: SPRINGROVE

23d. LOCATION (City, town or county) (State): DENTON, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Ingrid Moore for Skinner, Ltd — ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Emma S. Innes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03784

CERTIFICATE OF DEATH

03780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Queen Anne
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Church Hill 19X-2
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James Middle: Clay Last: Stevens

4. **DATE OF DEATH**: Month: March Day: 23 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9 - 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Thomas Stevens

14. MOTHER'S MAIDEN NAME: Elizabeth B. Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Clay Stevens — Address: Church Hill Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral Infarcts, recent & old.
DUE TO
(c): Hydro thorax, bilateral

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on March 19....., end that death occured at 4 P.M, from the causes and on the date stated above.

22a. SIGNATURE: E.C.H. Schmidt M.D.

22b. DATE SIGNED: 23 March 62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22d. ADDRESS: Easton, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/25/62

23c. NAME OF CEMETERY OR CREMATORY: Church Hill

23d. LOCATION (City, town or county): Church Hill (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Elgin L Sam — ADDRESS: Church Hill Md.

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03785

CERTIFICATE OF DEATH

03781

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 6 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Easton-rural
d. STREET ADDRESS: Goldsbrough Neck
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Philip — Middle: ------ — Last: Taylor

4. DATE OF DEATH: Month: MAR — Day: 28 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: April 26, 1897

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: ____ Days: ____
IF UNDER 24 HRS.: Hours: ____ Min.: ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming

10b. KIND OF BUSINESS OR INDUSTRY: agriculture

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Perry D. Taylor

14. MOTHER'S MAIDEN NAME: Ida Dean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: 217 36 0392

17. INFORMANT Address: Mrs. Bernard Messix, Queen Anne, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Coronary arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/15, 1962 to 3/28, 1962 that (I) (we) last saw the deceased alive on 3/28, 1962, and that death occured at 2:21 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. F. Cox, M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3/29/62

22c. PHYSICIAN'S NAME (Type): P. E. Cox

22d. ADDRESS: M. D. Easton, Md.
3/29/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/31/62

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemt.

23d. LOCATION (City, town or county) (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: W. Frampton Carroll — ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: APR 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

W. Frampton Carroll, Easton, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03786

CERTIFICATE OF DEATH

03782

Item 2 Inf. from birth certificate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (C) (M) 80 (I) 2 1

1. PLACE OF DEATH
a. COUNTY: Talbot
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 1/2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Easton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. #1 Queen Anne
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Baby Middle: Girl Last: Trice

4. DATE OF DEATH: Month: 3 Day: 22 Year: 1962

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 3/22/62

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: Days: 1
IF UNDER 24 HRS.: Hours: Min: 1 hr.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edgar D. Trice

14. MOTHER'S MAIDEN NAME: Joan Delores Trice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Joan Delores Trice, Queen Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anoxia of the brain — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Prolapse of the Cord
DUE TO (c): Prematurity - Breech Present.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/22/62, 19..., to 3/22/62, 19..., that (I) (we) last saw the deceased alive on 3/22/62 19 62, and that death occured at 8 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 4/4/62

22c. PHYSICIAN'S NAME (Type): KURT LEDERER

22d. ADDRESS: QUEEN ANNE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 3/25/62

23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

23d. LOCATION (City, town or county) (State): Easton, Maryland 4/4/62

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Memorial Hospital Easton Md

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VR (4) 61

2-059585

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03787 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03783

Items 8 & 9 Filmed 324 10/4/62 iwk

1. PLACE OF DEATH
a. COUNTY: T TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EASTON
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK Middle Last WALLEY

4. DATE OF DEATH: Month MARCH Day 28 Year 1962

5. SEX: MALE

6. COLOR OR RACE: COL

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: FEB. 14, 1899 (1895 6367)

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): TALBOT CO. MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES WALLEY

14. MOTHER'S MAIDEN NAME: LOTTIE WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 210-22-8206

17. INFORMANT: JAMES WALLEY Address: EASTON, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: IMMED.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): INFILT. RUL SUGG. AF INF. OR FRIEDLANDERS PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis S Welty M.D.

EXAMINER'S NAME (Type): LOUIS S. WELTY

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 3-30-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-31-62

22c. NAME OF CEMETERY OR CREMATORY: IVYTOWN CEMETARY

22d. LOCATION (City, town, or country) (State): NR EASTON MD.

23. FUNERAL DIRECTOR: James L Caskill ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE APR 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59